Fairfirst Worldwide Healthcare Outpatient Claim Form

To be completed by the Policyholder

Important notes:

This Claim Form is applicable for one patient only and must be completed and signed by the Insured/ Participant and/or Policy Holder or if the patient is a minor it must be completed and signed by the Insured/ Participant and/or Policy Holder in the capacity of parent or the Attending Physician. For incomplete form, it shall be returned, and no claim process shall proceed.

1. Documents that must be attached to this Claim Form shall include:
    a. Original receipts and the breakdowns.
    b. Details of drugs, copies of physician's prescriptions and details of drug prices.
    c. Physician's referral letter and copies of laboratory examinations, Radiology, CT Scan and other supporting checkups.
    d. For Physiotherapy, attach physician's referral letter and the schedule and frequency of therapy.
    e. For Glasses and Lenses, attach the dimensions of glasses/lenses taken from eye examination.
2. All claims must be submitted to Fairfirst Insurance no later than 30 (thirty) days after the treatment

1. Administrative

Policyholder		**Policy Number**	

Patients Details

Patient Name		**Date of Birth**	DD/MM/YYYY
ID/Passport No		**Gender**	Male / Female
Nationality		**Plan & Zone**	
Email ID		**Contact No**	
Relationship	Self I Spouse I Child I	**Consultation**	DD/MM/YYYY

GP/ Specialist Consultant Charges	
Prescription/Treatments/Medication Charges	
(Referral letter to be attached) lab/ Investigation Charges	
Other	
Total	

2. Patient/Policyholder's Declaration

I confirm that I am the patient or patient's parent, or guardian and I declare that all the particulars given above are to the best of my knowledge true and correct. I hereby consent to and authorize the medical practitioner involved in my or the patient's care to discuss and disclose treatment details, discharge arrangements and relevant medical history with and to Fairfirst Insurance Limited. I agree that a copy of this consent shall have the validity of the original.

In connection with my and/or my dependent's claims, I give consent for Fairfirst Insurance Limited and their respective representatives or agents to collect, use, store, transfer and/ or disclose the information (including that provided by sources other than myself) concerning me and/or my dependent's, to or with all such persons (including any member of the Fairfirst Group or any third party service provider, and whether within or outside of Sri Lanka and the Employer when claiming under a Group Policy) for the purpose of enabling Fairfirst and their respective representatives or agents to provide me and/or my dependent's (where applicable) with services required of an insurance provider, including the evaluating, processing, administering and/ or managing my and/or my dependent's claims with Fairfirst.

DD/MM/YYYY

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Patient/Policyholder Signature
(Parent's / Guardian's signature if Claimant is a Minor)

Date

3. Documents to be submitted

Please put a tick in the boxes below and submit the mandatory documents. If the mandatory documents are not submitted or partially submitted, your claim will only be processed upon receipt of the full documents. We reserve the right to determine if any of the documents below can be waived. We will notify you or your Financial Consultant if we need to obtain further information from you or other parties to assess your claim

- ☐ Claim Form which is to be completed fully (original)
- ☐ Original final itemized medical bills
- ☐ Original proof of payment/ payment receipt. (If claiming for a cash benefit, a copy of the final bill is acceptable)
- ☐ Copy of diagnostic test result (Laboratory result, X-Ray, etc.), Inpatient discharge summary report
- ☐ Copy of doctor's prescription for medicines purchased at an external pharmacy
- ☐ Copy of final itemized medical bills and Copy of Settlement letter from Insurer/ Employer (if claiming balances from another Insurer)

4. ADMINISTRATIVE SPECIFIC TO REIMBURSEMENT CLAIMS

Amount claimed	
Beneficiary name (IN CAPITAL LETTERS)	

Telegraphic bank transfer (Bank details will be required if previously not declared in application form)

Bank account number		Bank SWIFT code	
Name of bank		Bank Code	
Branch Name		Branch Code	

Payment will be made in Sri Lankan Rupees (LKR) unless we agreed otherwise in writing.

In which currency was the treatment originally billed	

Member's and Patient's details

Telephone Number		Mobile Number	
Email ID			

5. Procedure

5.1. Pay the doctor first

5.2. To complete the Claim Form - Outpatient

5.3. Kindly note that for a hospitalization or day surgery claim, you are required to complete a '**Claim Form – Inpatient (Reimbursement & Pre – Pre-Authorization)**' obtainable from Fairfirst Insurance

5.4. Kindly complete a '**Claim Form – Inpatient (Reimbursement & Pre – Pre-Authorization)'** claim form if this claim is related to pre or post-hospitalization.

5.5. Kindly submit a GP referral letter for specialist consultation.

5.6. Attach all the original bills/receipts you have paid and send to:

Fairfirst Insurance Limited – Health Claims Department
Access Towers II (14th Floor),
278/4, Union Place,
Colombo 02, Sri Lanka.

OR

Email - worldwidehealth@FAIRFIRST.lk

To avoid unnecessary delay in assessing your claim, please state your policy/member correctly and clearly overleaf.
Note: Claims submitted later than 30 days after the date of treatment may be declined.